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Original article

The choice and the change of the allocated primary mental health professional in community-based mental health services: a focus-group qualitative study

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SUMMARY

Objectives

It is generally agreed that it is important to take into consideration users' preferences in the choice of their allocated primary mental health professional (PMHP). Our aim was to explore experiences of users, care givers and psychiatrists on users' initial choice and request of change the PMHP in Community Mental Health Services (CMHSs).

Methods

Three focus groups were conducted in March-May 2017 in two CMHSs in Modena, Northern Italy. Transcripts were analyzed using MaxQda 11.

Results

Six users, 7 psychiatrists and 5 care givers were enrolled. Casual or fixed allocation is commonly performed (so-called "fixed rota"). Lack of empathy and a bad therapeutic relationship seem to be the most important reasons to change the PMHP.

Conclusions

Neither users nor professionals are generally involved in the initial choice of the PMHP. The availability of evidence-based guidelines for managing users' request to choose/change the PHMP may improve quality of care.

Key words: recovery, choice; primary mental health professional, community mental health, quality of care

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Conflict of interest
The Authors declare no conflict of interest

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Introduction

In recent times, healthcare has shifted from a paternalistic to a collaborative model [1], giving more importance to patients' Autonomy, one of the main principles of biomedical ethics [2].

In mental health care, the recovery model embodies this dramatic change of attitude, promoting service users' involvement in the co-construction of their pathways of care [3]. In line with such innovative principles, it is generally agreed that it would be important to take into account users' opinions about the relationship with their primary mental health professional (PMHP) in Community mental health services (CMHSs).

The UK National Health Service affirmed the right for users to choose their mental healthcare provider for out-patient treatment [4]. Similarly, this topic

has acquired an important role in the agenda of mental health care providers in Australia [5], New Zealand, USA and Canada [6]. In Sweden, recent reforms have encouraged the exercise of patient choice in outpatient settings not only in General Medicine, but also in other specialities, including mental health [7]. Users' organizations are vocal on the choice issue as part of their efforts to achieve parity between mental health and physical health [8].
Nevertheless, users' choice of mental health professional appears problematic and only partially applied in real practice [9]. In Italy, despite the presence of a long tradition of community-centred provision of mental health [10], users cannot generally choose their PMHP [11]. Only anecdotical reports exist that some Italian community mental health centres (i.e. the Department of Mental Health of Bologna) have locally implemented operative instructions guiding how to manage users' request to choose and/or change their PMHP.
Little research on this topic is available. Hill & Laugharne confirmed that patients would like to express their preference about their own PMHP in the NHS [12]. Similarly, a study investigating the opinions of 368 subjects with chronic depression found that the majority of them rated the free choice of their PMHP as important [13]. Matching in age, gender, ethnic and linguistic background seem to influence user preferences, but studies are few, small in size and far from being conclusive.
To our knowledge, no study explored users', caregivers and psychiatrists view on this topic by means of focus groups and grounded theory qualitative analysis.
Therefore, the aim of this study was to explore users, care givers, and psychiatrists' attitudes, opinions and personal experiences towards the topic of the choice and the change of the allocated PMHP in CBMHSs.

Material and methods

Study design

This is a qualitative research, conducted according to the grounded theory methodology [14]. Three focus groups were implemented in order to explore, respectively, users, caregivers and psychiatrists' attitudes and opinions on the research topic. The study was reported according to COnsolidated criteria for REporting Qualitative research (COREQ) principles for qualitative research [15].

Research team and reflexivity

The first focus group was conducted by GR and BG, the second by CA, AM and RV, the last one by NG and GG; researchers were residents in Psychiatry at the University of Modena and Reggio Emilia respectively at their second (GR, AM, NG) and third (CA, GG) year of training, at the time of the study. RV and BG were final year medical students. GMG, Associate Professor in Psychiatry at the University of Modena and Reggio Emilia, supervised the general research methodology.

Participant selection

All users, care givers and psychiatrists of the two community mental health centres in the town of Modena, North of Italy, were invited to the focus groups, without limitation of sex, age or disorder.
On January 2017, an e-mail describing the study was sent to the directors of the centres, including a flyer invitation to the focus groups to be forwarded to all users, care givers and psychiatrists. Flyer invitations were also posted to the walls of the out-patient clinics. The flyer invitation illustrated the project and reported date, location, time and duration of the focus groups; a phone contact was also provided. Participation in the focus group was voluntary. No interactions or personal contacts were established prior to the study between researchers and participants.

Setting

The three focus groups were held in the meeting room of one of the mental health centers. Each group had an expected duration of 90 minutes. At the beginning of each focus group, researchers briefly introduced themselves, and provided information on how to proceed with the group activity.

Data collection

During the meetings, field notes were taken by a co-facilitator and used later in the coding phase. Meetings were audio-recorded. After the focus group, each participant was asked to fill in a research questionnaire collecting socio-demographic and clinical (when applicable) variables; the questionnaire also explored previous experiences and opinions on the investigated topics and prompted further feedbacks, in order to reach theoretical data saturation. A second questionnaire was subsequently sent by e-mail to each psychiatrist who participated in the study, as respondent validation. Transcripts were not returned to participants for comment and/or correction.

Data analysis

Rough, anonymized transcripts of the focus groups' audio-recordings were analysed independently by two researchers (BG, GR) by means of MaxQda 11 software (VERBI GmbH) so as to develop a hierarchical code system *a posteriori* (derived from the data), with the independent supervision of a third researcher (RV), according to the principles of grounded theory.

Data reporting

Data were reported according to the COREQ. The COREQ checklist for this study is available for readers as supplementary material.

Ethics

This research work was part of the wider research project "The choice and change of Mental Health Care provider in Community Mental Health services", approved by Modena Ethics Committee (EC 270/16-Protocol number 204/CE) on 24/1/2017. Written and signed informed consent was obtained from each participant; the study was performed according to the principles of the Declaration of Helsinki and to the Clinical Good Practice rules for medical research.

Results

The three focus groups were conducted on March, 17th 2017 (users), May, 8th 2017 (care givers) and May, 23rd, 2017 (psychiatrists). Six users (4 males, 2 females; mean age 34 ± 13.37 years) attended the first focus group; 5 care-givers (1 male, 4 females; mean age 59.2 ± 16.78 years) attended the second; 7 psychiatrist (2 females, 5 males; mean age 54.29 ± 10.49 years) attended the third and final.

All participants completed the research questionnaire at the end of each focus group. Five of the 7 (71.43%) psychiatrists also completed the respondent validation questionnaire.

At the MaxQda analysis, the first focus group provided 85 coded segments, the second 57 and the third 57. Coded segments were grouped *a posteriori* in 2 thematic macro-areas: 1) the initial choice of the PMHP (71 segments form the first focus group, 23 from the second and 13 from the third); 2) the request to change the allocated PMHP (4 segments from the first focus group, 10 from the second and 44 from the third). Table I provides the retrospective hierarchical code system and results of the qualitative analysis of each focus group.

Figure 1 provides a coding tree of the major and minor explored themes.

TABLE I. *Retrospective hierarchical code system and results of the qualitative analysis.*

USERS' FOCUS GROUP		
Macro area	**Sub-codes**	**Number of coded segments**
Choice of the PMHP	Possible	0
	Not possible	4
Request to change the PMHP	Modality	7
	Motivation	
	Empathy	6
	Perceived care	1
	Logistic reasons	1
	Ethnicity	0
	Religious/cultural background	5
	Gender	6
	Age	6
	Unwanted change	10
	Subjective difficulties	4
	Desire to follow the psychiatrist in another service	6
PSYCHIATRISTS' FOCUS GROUP		
Macro area	**Sub-codes**	**Number of coded segments**
Choice of the PMHP	Possible	5
	Not possible	2
	Modality	3
Request to change the PMHP	Modality	3
	Motivation	

TABLE I. *continue*

Macro area	Sub-codes	Number of coded segments
	Outcome	1
	Specific competence	2
	Duration of the relationship	4
	Gender	1
	Age	1
	Possible	3
	Not Possible	1
CARE GIVERS' FOCUS GROUP		
Macro area	**Sub-codes**	**Number of coded segments**
Choice of the PMHP	Possible	1
	Not possible	8
	Modality	1
Request to change the PMHP	Modality	2
	Motivations	6
	Privacy	2
	Previous involuntary Admission	4
	Empathy	10
	Ethnicity	1
	Religious/cultural background	1
	Gender	4
	Age	0
	Unwanted change	5
	Subjective difficulties	4
	Desire to follow the PMHP	1

A brief summary of the main findings of the study is displayed in Table II.

The choice of the PMHP

According to all participants and to users' personal experience in community-based mental health settings, the usual method of initial allocation of a service user to a PMHP is via a "fixed rota" and it usually takes place usually during team meetings, so that generally users, as well as professionals, can not have a say in the initial choice of their PMHP.

Psychiatrists confirmed that, to the best of their knowledge, no guidelines regulating users' involvement in the choice of their PMHP are currently available.

Users also said that, especially at the very first contact with services, people generally have neither full awareness of their right to choose, nor sufficient information on the nature of mental disorders and their possible treatments to properly guide an informed choice of the PMHP.

The group of psychiatrists alone highlighted the organizational and practical issues supporting the system as it is (the rota system described above), which serves the aim to evenly distribute across professionals the often very high caseload. A smaller caseload (that is, an increase in the number of mental health providers) could allow to take into consideration users' requests. Most users and care givers expressed their disappointment at being denied choosing their own PMHP.

"What I regret is that I would also have preferred to take part in the doctor's decision" (a care giver).

"In the same way that patients can choose their own GP, it would be appropriate for psychiatric patients to have the opportunity at least to exhibit their own personal choice regarding the PMHP" (a psychiatrist).

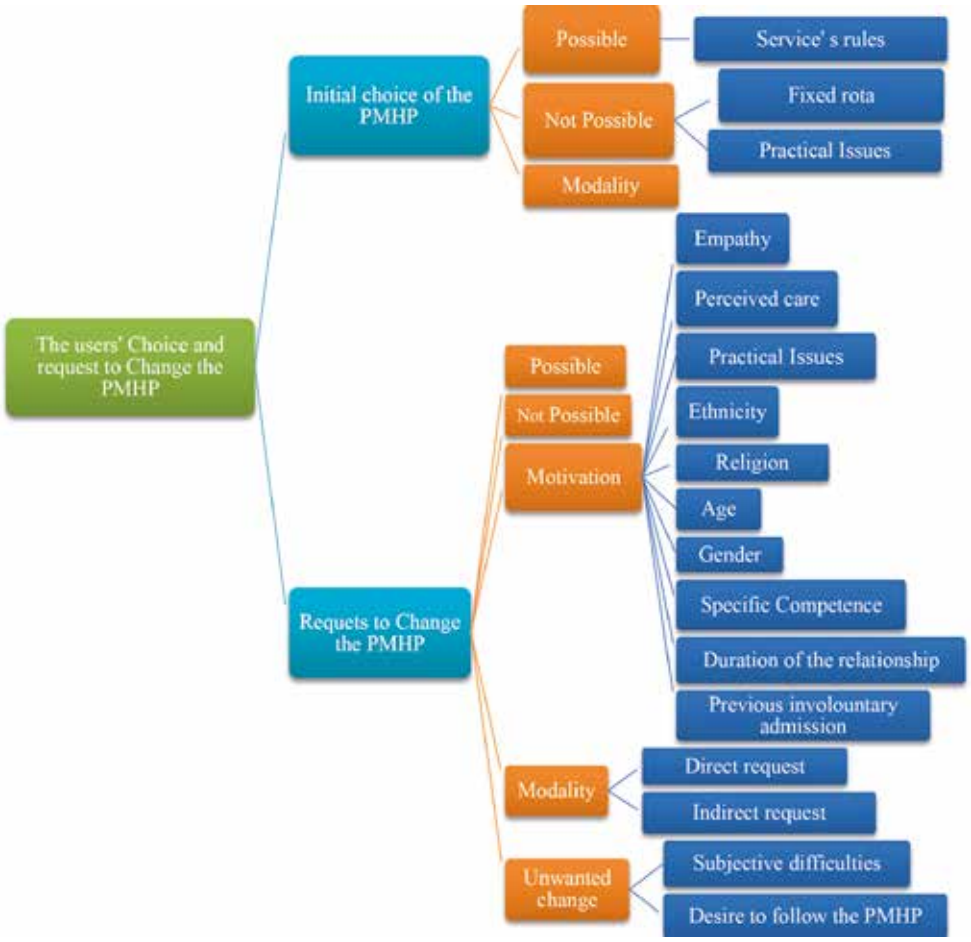

FIGURE 1. *Coding tree of the major and minor themes explored in the focus groups.*

TABLE II. *Summary box of the main findings of the study.*

Main OVERLAPPING THEMES
The feeling and empathy between the PMHP and the user is considered essential for a good therapeutic relationship
The management of drug therapy is a very sensitive topic for both patients and caregivers, and can influence the need to choose/change the allocated PMHP
The management of the request to choose/change the allocated PMHP is highly regarded as relevant. There is the need for well-defined policies to deal with these requests in Community Mental Health Centres.
Allocation via a fixed rota is the usual sytem to allocate PMHP to service users: users and professionals are not generally involved in the initial choice.
The lack of empathy and a bad therapeutic relationship seem to be the most important reasons behind the request to change the PMHP
The topic was considered "relevant" or "very relevant"
SPECIFIC THEMES FROM THE FOCUS GROUP OF PSYCHIATRISTS
Caseload size influence the way requests for choosing/changing the PMHP are dealt with: a smaller workload would allow a more accurate management and a higher rate of acceptance
PMHPs may also be given the possibility to request to change patients, especially after long-term relationships or when the therapeutic relationship is felt to be "at a deadlock"

According to users and most of care givers, the free initial choice of the PMHP would in fact be considered as an opportunity for active involvement of the user in his care process.

"An advantage of being able to choose your own doctor would be to make the patient more involved in the therapeutic process" (a user).

The request to change the allocated PMHP

Most of participants acknowledged that a user's request to change the allocated PMHP is generally at least discussed, and a change granted more often than it used to be years ago.

"Usually today if one proposes a change they change it, it is not like it used to be" (a user).

Empathy in the therapeutic relationship is the most important reason prompting a request to choose or change the PMPH, according to users. Therapeutic relationships described as "good" feature reciprocal trust, the PMHP accessibility and the user's experience of being actively listened during sessions. Requests of changing therapist usually come up when such features are felt to be lacking.

"Empathy is felt differently from person to person and it may be that a psychiatrist is good for one person but is not good for another; this is not a failure, it is a change" (a user).

Care givers as well emphasized the importance of empathy in the users/PMHP therapeutic dyad, and the role of poor empathy as a reason to ask for a different doctor. Furthermore, care givers outlined that especially in long-lasting therapeutic interactions which are frequent in mental health care, it may be that a change of the PMHP every now and then could result in improved recovery.
The psychiatrists added that it may be not only the user wanting to change the PMHP, but also the other way round, the PMHP wanting to change users: after a certain amount of time, the therapeutic relationship may reach a stagnation point and a change could improve satisfaction and other outcomes.
Care givers also suggested that having experienced an involuntary admission may be a reason for users' wanting to change the PMHP who took such decision. Psychiatrists strongly expressed their disagreement on such motivation to be considered valid.

"If a person who has 'been at the service' for ten years undergoes an involuntary admission, perhaps it is a sign that there is something that is not going well in the care pathway" (a care giver).

Participants in all the three focus groups expressed conflicting opinions about the topic of age, gender, ethnicity or religion concordance between the PMHP and the user as an appropriate reason to ask for a change. A request to change the PMHP motivated by the desire to achieve age and gender matching was considered appropriate by care givers and users, but of little or no importance according to psychiatrists. One user also expressed the fear that a younger age of the PMHP may be a sign of less clinical experience. Users did not express the need for ethnic concordance, only one care giver suggested that ethnic matching could be a good reason to request the change of the PMHP.
Finally, according to both psychiatrists and care givers, the PMHP expertise in managing the specific disorder affecting the user may be a valid criterion for allocation or re-allocation.
Psychiatrists informed that no official service or department policy was available to help dealing with users' requests to change PMHP. One of the two mental health centers implemented a list of operative instructions in case of such requests, which essentially consists in submitting them to the senior Consultant of the community mental health centre and discussing them with users', relatives and the CBMHS team.
Users felt that specific information and options on how to change PMHP should be given to them. They agreed that requests of change which happen after a considerable duration of the therapeutic relationship, should be given a priority.
The opposite scenario of unwantedly having to change the allocated PMHP, for example because of the user relocating to a different catchment area, or because of a temporary absence or definitive retirement of the psychiatrist, was also discussed. Four users and one care giver expressed the desire to keep on with the same PMHP anyway. It was a shared opinion that to suffer an unwanted change may cause of serious discomfort for users, especially if a substitute is not immediately available. Users asked to be informed and psychologically prepared about the possible change of their allocated PMHP.
All participants agreed that discussing the topics of the choice and change of the PMHP is relevant and that it would be helpful if specific policies were developed and implemented in CMHSs.

Discussion and conclusions

There was agreement among participants on considering the topic of the choice and change of PMHP as a very relevant one to discuss. This finding is in line with previous studies [12,13].
Problems in establishing a good empathic therapeutic relationship was commonly recognized as the main mo-

tivation prompting a request to change the PMHP. This finding is also in line with previous studies, showing that mental health service users, not surprisingly, express their preference for a supportive, flexible, respectful and professional relationship [16], based on trust [17].

Age, gender and ethnicity matching were generally not considered sufficient motivations for requesting a specific PMHP or to change PMHP if users had a specific preference in regard to these characteristics in the PMHP. With respect to gender, this finding is consistent with previous studies investigating users' gender preferences [18,19]. As to ethnicity, this results is in contrasts with some studies [20-25] that showed that users tend to prefer therapists of their ethnicity. It must be noticed that several of these previous studies were implemented across ethnic minorities; also, Italy has been a multi-ethnic society for much less time than other countries, and to a much less extent, possibly limiting the development on the discourse on the issue of ethnic concordance in the dyad PMHP-users.

In the user and care giver groups, the opposite issue, that is the desire of maintaining the relationship with the allocated, PMHP provided results similar to those outlined by previous studies, showing that sudden changes of PMHP were experienced as setbacks in treatment [26]. Psychiatrists described the lack of policies to support mental health workers in dealing with these requests. Request of change may come not only from users or caregivers, but also mental health professionals may need a change at times.

Finally, while care givers suggested that having experienced an involuntary admission may be a reason for users' request to change the PMHP who took such decision, psychiatrists did not consider such motivation as valid. This result from the focus group of psychiatrists is quite surprisingly, because it is well known that several previous studies on users' perceptions of coercion showed that compulsory admissions may be related to anxious, depressive and even traumatic symptoms. Therefore, these users' experiences could reasonably justify their request to change the PMHP who ordered their previous involuntary treatment [27,28].

A few limitations in the present research should be acknowledged, especially as a consequence of the qualitative methodology adopted. Firstly, as in every focus group occurs, participants were self-selected and study results are therefore harder to generalize to the larger population. Secondly, the respondent validation analysis was not possible for all the participants, because of the majority of users and care givers did not share their personal e-mail contacts to researchers. On the contrary, all psychiatrists received and completed the respondent validation questionnaire via their institutional e-mail. Finally, transcripts were not returned to participants for comments or corrections because the audio-records of the whole focus groups were literally transcribed, thus limiting the risk of transcription error; as several papers on member checks in qualitative research underlines, this limitation is unlikely to significantly affect research findings [29,30].

In conclusion, improvement of users' involvement in decision-making is a relevant topic according to the recovery model of care, and more research is warranted on effective methods to achieve it. Users, care givers and psychiatrists' views should be better explored, in order to discuss ethical and practical issues and to elaborate policies to appropriately manage users' requests of a change of PMHP. Discussion and sharing experiences at a regional and national level should be promoted, as well as relevance and feasibility in different clinical settings.

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References

1 Pelto-Piri V, Engström K, Engström I. Paternalism, autonomy and reciprocity: ethical perspectives in encounters with patients in psychiatric in-patient care. BMC Med Eth 2013;14:49. https://doi.org/10.1186/1472-6939-14-49

2 Beuachamp TL, Childress JF. Principles of biomedical ethics. 5th Ed. New York: Oxford University Press 2001.

3 Anthony WA. Toward a vision of recovery for mental health and psychiatric rehabilitation services, 2nd Ed. Boston, MA: Center for Psychiatric Rehabilitation, Boston University 2007.

4 Department of Health. More choice in mental health press release. Department of Health, 2012 (https://www.gov.uk/government/news/more-choice-in-mental-health).

5 Peterson S, Buchanan A, Falkmer T. The impact of services that offer individualised funds, shared management, person-centred relationships, and self-direction on the lived experiences of consumers. Int J Ment Health Syst 2014;8:20.

6 Warner L, Mariathasan J, Lawton-Smith S, et al. Choice literature review. London, UK: The Sainsbury Centre for Mental Health and King's Fund, 2006.

7 Glenngård AH, Hjalte F, Svensson M, et al. Health systems in transition. Sweden, Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005.

8 The National OCD Charity. You right to choose (https://www.ocduk.org/overcoming-ocd/accessing-ocd-treatment/access-

ing-ocd-treatment-through-the-nhs/right-to-choose).

9 Veale D. Choice of provider for out-patient treatment is not working. B J Psych Bulletin 2018;42:82-5. https://doi.org/10.1192/bjb.2017.25

10 Fioritti A, Amaddeo F. Community mental health in Italy today. J Nerv Ment Dis 2014;202:425-7.

11 Barbato A, D'Avanzo B, D'Anza,V et al. Involvement of users and relatives in mental health service evaluation. J Nerv Ment Dis 2014;202:479-86.

12 Hill S, Laugharne R. Patient choice survey in general adult psychiatry. Psychiatry Online 2006 (http://priory.com/psych/cornwall.pdf).

13 Groenewoud S, Van Exel NJ, Bobinac A et al. What influences patients' decisions when choosing a health care provider? Measuring preferences of patients with knee arthrosis, chronic depression, or Alzheimer's disease, using discrete choice experiments. Health Serv Res 2015;50:1941-72. https://doi.org/10.1111/1475-6773.12306

14 Strauss A, Corbin J. Grounded theory methodology. Handbook of qualitative research 1994;17:273-85.

15 Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care 2007;19:349-57.

16 Grant JG, Mandell D. Boundaries and relationships between service users and service providers in community mental health services. Soc Work Ment Health 2016;14;696-713.

17 Woltman EM, Whitley R. Shared decision making in public mental health care: perspectives from consumers living with severe mental illness. Psych Rehab J 2010;34:29-36.

18 Manthey RJ, Vitalo RL, Ivey AE. The effect of client choice of therapist on therapy outcome. Commun Ment Health J 1982;18:220-9. https://doi.org/10.1007/BF00754338

19 Turchik JA, McLean C, Rafie S, et al. Perceived barriers to care and provider gender preferences among veteran men who have experienced military sexual trauma: a qualitative analysis. Psychol Serv 2013;10:213-22. https://doi.org/10.1037/a0029959

20 Ziguras SJ, Klimidis S, Lambert TJR, et al. Determinants of anti-psychotic medication compliance in a multicultural population. Commun Ment Health J 2001;37:273-83.

21 Lorefice LS, Borus JF. Consumer evaluation of a community mental health. Am J Psychiatry 1984;1:1-1.

22 Knipsheer JW, Kleber RJ. The importance of ethnic similarity in the therapist-patient dyad among Surinamese migrants in Dutch mental health care. Psychol Psychother Theor Res Pract 2004;77:273-8.

23 Flaskerud JH, Liu PJ. Effects of an Asian client-therapist language, ethnicity and gender match on utilization and outcome of therapy. Commun Ment Health J 1991;27:31-42.

24 Flaskerud JH. The effects of culture-compatible intervention on the utilization of mental health services by minority clients. Commun Ment Health J 1986;22:127-41.

25 Sue S, Fujino D, Hu L et al. Community mental health services for ethnic minority groups: a test of the cultural responsiveness hypothesis. J Consult Clin Psychol 1991;59:533-40.

26 Biringer E, Hartveit M, Sundfør B, et al. Continuity of care as experienced by mental health service users – a qualitative study. BMC Health Serv Res 2017;17:763.

27 Priebe S, Bröker M, Gunkel S. Involuntary admission and posttraumatic stress disorder symptoms in schizophrenia patients. Compr Psychiatry 1998;39:220-4.

28 Cohen LJ. Psychiatric hospitalization as an experience of trauma. Arch Psych Nurs 1994;8:78-81.

29 Thomas DR. Feedback from research participants: are member checks useful in qualitative research? Qual Res Psychol 2017;14:23-41.

30 Hagens V, Dobrow MJ, Chafe R. Interviewee transcript review: assessing the impact on qualitative analysis. BMC Med Res Methodol 2009;9:47.